NEW PATIENT INTRODUCTION SHEET

Please print *all sections legibly and sign below.*

Personal Date: _____

Last Name: _____First Name: _____

Nickname: _____Address:_____

City: _____ State: _____ Zip: _____

Social Security #: _____-_____-_____ Gender: M F

Marital Status: S M D Sep. W Spouse Name:_____

Date of birth:_____ Home # ( ) _____

Work # ( ) _____ Cell# ( ) _____ Cell Carrier: _____

Would you like to receive text messages, i.e. appointment reminders? Yes No

E-mail: _____ Emergency Contact: _____

Referred by: _____

Employer: _____ Occupation: _____

Employer Address: _____

Illness/Accident Information:

Was there an accident or injury? Yes No If yes, what was the date _____

Did it occur at work? Yes No Did it occur in an automobile Yes No

What are the Health Concerns:

1st concern: _____

2nd concern: _____

Others: _____

Has it happened before? Yes No If yes, when _____

Have you had Chiropractic before? Yes No If yes, when? _____

Were you examined? Yes No Were X-rays taken? Yes No

Name of the Chiropractor: _____ Phone #: _____

Present reason for consulting this office (mark which applies)

_____ I am interested in getting well and staying well

_____ I am interested in temporary relief only

_____ I would like the doctor to make recommendations

_____ I am here for a complimentary consultation only

Is the patient a minor? If yes please complete the Minor's Introduction sheet

Insurance Processing: We will create the billings for you to send to your insurance company for them to reimburse you. Please provide the information to our staff.

Financial Arrangements

The initial consultation is at no charge. From that discussion, Dr. Miller will make recommendations for an evaluation tailored to the individual situation. Our office policy is for the patient to pay for any services rendered after the initial consultation in all cases. The patient is ultimately responsible for payment regardless of the type of account. Should there be financial challenges please bring them to our attention promptly so we can assist you.

Signature: _____ Date: _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know (actually your insurance company more than us) how much your pain ***presently*** prevents you from doing what you would normally do. Indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities from ***completely able (0)*** to function to ***totally unable (10)***

1. **FAMILY/AT -HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS WITH FRIENDS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

6. **LIFE -SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TOTALLY UNABLE

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK -5 = _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjust to correct vertebral subluxations.

I, _____have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Witness: _____ Date: _____